MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22CI	A. BUILDING: _____ B. WING _____	C 03/03/2023

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GRENADA REHABILITATION AND HEALTHCARE CEN	1966 HILL DRIVE GRENADA, MS 38901

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M 000	Initial Comments The State Agency (SA) conducted three (3) Complaint Investigations (CI) from 2/27/2023 to 3/3/2023 for CI MS #20856, CI MS #20857, and CI MS #20895. During the survey, the facility was determined not to be in substantial compliance with the requirements of participation for the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The SA identified non-compliance and cited M640 for CI MS # 20856 for failure to provide supervision to prevent elopement. No deficiencies were cited for CI MS # 20857 or CI MS # 20895. On 2/23/2023, at approximately 9:53 PM, the local Hospital Emergency Room (ER) called the charge nurse to inform the facility that Resident #1 was in the ER and looked "beat up" with lacerations and bruising. The Hospital Emergency Nurse said he still has his wander guard bracelet on. The Certified Nursing Assistant (CNA) and Assistant Director of Nursing (ADON) looked into Resident #1's room and noticed that his window was open, and the screen had been bent/broken out and up to allow him to get out of the facility. Resident #1 was last observed in the facility around 9:00 PM. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 1/21/2023 when the facility failed to provide supervision to Resident #1 who was a wandering risk and displayed exit seeking behaviors and left the facility unnoticed and unsupervised on 2/23/23. The facility's failure to provide supervision for Resident #1 placed this resident and other resident(s) at risk, in a situation that was likely to	M 000		

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M 000	Continued From page 1 cause serious harm, injury, impairment, or death. On 3/2/2023 the SA notified the Administrator of the IJ and Substandard Quality of Care (SQC) and provided the facility with the IJ templates. The IJ and SQC existed at: Rule 45.21.8 - M640 Accidents Hazards - Level IV The facility provided an acceptable Removal Plan on 3/2/2023, in which the facility alleged all corrective actions were completed to remove the IJ on 3/2/2023, and the IJ removed on 3/3/2023. The State Agency (SA) determined the IJ was removed on 3/3/2023, prior to exit, and the scope and severity for M640 was lowered from a Level IV to a Level II, while the facility develops and implements a plan of correction and monitors effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The census at the time of survey was 88, and the facility held a license for 139 beds.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by:	M 640		3/31/23

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M 640	Continued From page 2 Based on observation, interview, record review, and facility policy review, the facility failed to provide supervision to prevent a resident from leaving the facility unsupervised for one (1) of three (3) residents reviewed. Resident #1. The facility failed to provide supervision to prevent elopement for Resident # 1, who was a wandering risk. The resident left the facility through a window unnoticed and unsupervised until the resident was in a community approximately 236.22 feet away from the facility. The Resident was last seen in the facility at 9:00 PM on 2/23/2023. He was not discovered to be missing until 9:53 PM on 2/23/2023 when the facility was notified by the local hospital Emergency Room (ER) that Resident #1 was in the ER. The facility's failure to provide supervision to a resident who was a wandering risk placed Resident #1 and all residents who were at risk for wandering in a situation that has caused or is likely to cause serious harm, injury, impairment, or death. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 1/21/2023 when the facility failed to provide supervision to Resident #1 who was a wandering risk and displayed exit seeking behaviors. Resident #1 left the facility unnoticed and unsupervised on 2/5/2023. The facility Administrator was notified of the IJ on 3/2/2023 at 10:15 AM. The facility provided an acceptable Removal Plan on 3/2/2023, in which the facility alleged all corrective actions were completed to remove the IJ on 3/2/2023. The SA validated the Removal plan on 3/3/2023	M 640	M 640 Failure to Provide Supervision to Prevent Elopement 1. On 3-2-2023, Root Cause Analysis (RCA) was conducted by the Interdisciplinary Team (IDT). On 2-24-2023, the Maintenance Department checked the Wander Guard System/Doors with no areas of concern nor malfunctions noted and added window alarm devices to Resident #1's new courtyard room. 2. Quality reviews of current Residents' care plans were conducted on 3-2-2023, by the Director of Nursing (DON), Minimum Data Set Nurse (MDS), and RDCS to ensure appropriate interventions were in place for residents who displayed exit seeking behaviors. One resident out of eighty-eight had the potential to be affected. 3. On 2-23-2023, the ADON initiated all staff members in-services on Abuse/Neglect, Resident Rights, Vulnerable Adults and Elopement policy and procedures which included, but does not limit to: Identification & Prevention of elopement, interventions, and documentation, at risk for elopement; monitoring, interdisciplinary interventions, door alarm sounds, procedure for missing residents/elopement, what to do when resident is found, and actions post elopement. On 3-2-2023, the Regional Director of	

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M 640	Continued From page 3 and determined the IJ and SQC was removed on 3/3/2023, prior to exit, and the scope and severity for Rule 45.21.8 M640 was lowered from a Level IV to a Level II, while the facility develops and implements a plan of correction and monitors effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Record review of the facility policy titled "Wander Management, Monitoring System & Resident Elopement Protocol reviewed 01/2023 revealed "Purpose: To monitor safety of residents at risk for elopement. To provide a system to alert staff that a resident may be attempting to leave the facility. Policy: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible..." Record review of the facility investigation revealed "Resident: (Formal Name of Resident # 1), BIMS(Brief Interview for Mental Status) score of 14, Primary Diagnosis: Malignant Neoplasm of Nasopharynx, Unspecified. On 2/23/2023, (Formal Name of Resident #1), Resident exited the facility via his bedroom window between 21:00 and 21:53. At approximately 21:00 (Formal Name of Certified Nursing Assistant #1)and (Formal Name of Licensed Practical Nurse #1) witnessed (Formal Name of Resident #1) walk into his private single person bedroom and shut the door, both staff members state that (Formal Name of Resident #1)'s wander guard bracelet was on his ankle when they saw him enter his room. At 21:53 (Formal Name of Local Hospital Emergency Room) Charge Nurse called the facility to report (Formal Name of Resident # 1) was at the Emergency Room. (Formal Name of	M 640	Clinical Services (RDCS) in-serviced the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on identifying residents at risk for wandering/elopement and that they have the appropriate interventions in place. No employee will be allowed to return to work without the training and education with new hires will be conducted in orientation. 4. The Nursing Home Administrator and or Maintenance Director will monitor Resident #1 room's window alarm devices and the Wander Guard System/Doors 3 x weekly for 1 month, then weekly for 1 month and then monthly for 2 months beginning 3-6-2023 to ensure safety devices are in compliance. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 3-30-2023. The monitoring schedule will be revised based on findings.	

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M 640	Continued From page 4 Resident # 1) exited his bedroom by sliding open the side section of his private room bedroom window and bending the window screen open wide enough for him to crawl out. (Formal Name of Resident # 1)'s wander guard bracelet was in place and functioning properly as were the door wander guard systems prior to the elopement and even after (Formal Name of Resident #1) returned from (Formal Name of Local Hospital) Emergency Room. Upon his return from (Formal Name of Local Hospital) Emergency Room on 2-24-2023, (Formal Name of Resident #1) was placed on one-on-one observation beginning at approximately 01:45 until 06:00, and then 15-minute checks which he remains on it. On 2-24-2023, (Formal Name of Resident # 1) was moved from (Resident #1's previous room) to (Resident # 1's new room) (courtyard room), and a window alarm device were placed on the windows in (Formal Name of Resident #1)'s new room (Resident #1's room).On 2-23-2023 (Formal Name of State Agency) and the AG (Attorney General's) office were notified. Resident's Responsible Party and Physician were notified of the allegation and informed that an investigation was being conducted. Throughout the investigation Employee witness statements were collected, Resident body audit was conducted, one on one resident observation initiated, 100% audit of wandering risk residents conducted, 100% audit residents were assessed for being at risk for elopement, Wander Guard System/Door were checked by Maintenance Department with no areas of concern nor malfunctions noted, and window alarm devices were added to (Formal Name of Resident # 1)'s new courtyard room... Staff members were in-serviced on Abuse/Neglect, Resident Rights, Vulnerable Adults and Elopement policy and procedures. In conclusion, the allegation of abuse or neglect on	M 640		

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behalf of the facility is unsubstantiated. I do substantiate that (Formal Name of Resident #1) (BIMS 14) did exit the facility via his bedroom window because he has a strong desire to not be in a Nursing Home and wants to go home ..."

An interview with Registered Nurse (RN) #1 on 2/27/23 at 2:00 PM, revealed that she was on duty as Charge Nurse on 2/23/23 and received a call from the local Emergency Room (ER) at 9:53 PM notifying her that Resident #1 was in the ER and that he had been picked up by the ambulance in the neighborhood behind the facility. She stated that she and Certified Nursing Assistant (CNA) #2 went to Resident #1's room and noticed that the window was open, and the screen was broken. When she went outside to the back of the building she saw the resident's phone, house shoe, glasses, and jacket. She stated that Resident #1 must have gone through the fence and creek because his clothing was wet when he got to the hospital. She stated that she went to the ER to check on Resident #1 and noticed a laceration on his head and abdomen. RN #1 stated that Resident #1 was last seen by the floor nurse and CNA #2 around 9:00 PM going into his room.

In an interview with the Administrator on 2/27/23 at 2:08 PM, he revealed that the resident attempted to exit the building last month.

Upon interview with the dispatcher for the local ambulance service on 2/27/23 at 2:29 PM, she stated that Emergency Medical Services (EMS) received a call to respond to an address in a local neighborhood at 9:12 PM on 2/23/2023. EMS picked up Resident #1 at 9:18 PM and took him to the local ER.

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An interview with LPN #1 on 2/27/23 at 3:15 PM, revealed that she was on duty on the 3-11 shift on 2/23/23 and last saw Resident #1 during the night med pass around 9:00 PM. She stated that he was ambulating up and down the hall and went into his room. LPN # 1 also revealed that she witnessed an incident on 2/21/23 in which the resident became agitated and attempted to get out by using the advanced entry check in machine to try to break a window near one of the exits. She stated that it was obvious that the resident was going to get out any way he could but did not think that he would go out the window.

A telephone interview with CNA #1 on 2/27/23 at 3:57 PM, revealed the resident likes to wander and they try to keep him out of the room and in visual site as much as possible. She revealed that on the night of the 2/23/23 Resident #1 went into his room around 9:00 PM. She stated that Resident #1 really needs one on one (1:1) care. CNA #1 stated that if Resident #1 had 1:1 and maybe take him outside to a safe spot so he didn't feel like he was trapped, that maybe they could have talked him out of going out the window.

An interview with LPN #3 on 2/28/23 at 11:20 AM, revealed that she is familiar with the resident and that he wanders through the facility and is exit seeking. She states that they give him snacks and try to monitor and redirect him. She states that at times the resident becomes obsessed with things until he gets them.

An interview with Resident #1 on 2/28/23 at 11:30 AM, revealed that he did not recall how he obtained the laceration to his head or leaving the building to go home. Resident #1 stated he had $100,000 in the bank and needed some dry

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clothing and began propelling himself down the hall in the wheelchair.

An interview with CNA # 2 on 2/28/23 at 4:00 PM, she revealed that she was the CNA assigned to Resident #1 on the 3-11 shift on 2/23/23. She stated that Resident #1 does wander, and they have to monitor him and redirect him. CNA # 2 stated that she did not look at her watch but that she thinks it was around 9:00 PM when she saw Resident #1 go into his room and shut the door while she was on the way to care for another resident. She stated the resident will usually take a nap for a couple of hours and then get up again.

On 3/1/23 at 1:45 PM, an interview and observation with the Maintenance Supervisor revealed that the side window would open at the top and the resident bent the top half of the screen down enough to climb out. On the outside of the building, the window was directly over a concrete drain. The Maintenance Supervisor revealed there was blood found on the concrete drain the morning after the resident eloped. Directly across from his window and the building there was a chain link fence that still had a torn piece of the black T-shirt the resident was wearing the night he eloped and approximately 5 feet down the bank was a house shoe. The bank was very steep and had fallen tree debris and large broken pieces of concrete on both sides. At the bottom of the bank was a creek approximately 5 (five) feet wide and the bank on the other side of the creek was just like the one closest to the building. At the top of the bank were backyards to houses in a subdivision. The Maintenance Supervisor stated the resident climbed out of the window, climbed over the chain link fence, across the creek, up the bank on the

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other side of the creek and into the backyards of those houses. The Maintenance Supervisor stated they moved the resident to a room that opens onto the courtyard of the facility and has alarms on the window.

On 3/2/23 at 3:00 PM, an interview with RN # 1, revealed that when the resident returned from the ER on 2/24/23 he was wearing a black T-shirt that was torn, wet, and muddy, a pair of black slacks that were wet and muddy, and one house shoe. He had a laceration on his head with staples and about 4 scratches on his abdomen.

An interview with Officer #1 on 3/1/23 at 7:15 PM, who responded to the initial 911 call on 2/23/2023 revealed, he was unsure of the exact time of the call or time of his arrival. He indicated it was after 9:00 PM. He stated that Resident #1 had been knocking on doors in the neighborhood looking for help. Officer #1 stated that the resident was confused, agitated, and difficult to understand. He stated the resident's clothing was wet and he had blood on his hands that was coming from his head. Officer #1 stated Resident #1 was released to EMS when they arrived.

A record review of the local Emergency Medical Services (EMS) report titled "Patient Care Report", revealed local EMS responded to a 911 call, arrived at the given address at 9:18 PM and noted that Resident #1 was sitting on the ground on the roadside. The Local Police Department was present. Resident # 1 had dried blood to the left side of his head and abrasions to the abdomen. Resident # 1 had walked up to someone's door and tried to enter the house and they called 911.

A record review of the local Hospital Emergency

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Department (ED) report titled "ED Notes" revealed on 2/23/2023 at 9:49 PM Resident #1 arrived at the ED via EMS after police responded to him being found in a stranger's yard. Resident #1 had a 3 centimeter (cm) laceration to his scalp, requiring 4 staples, and lacerations down and across his abdomen. The ED notified the facility that Resident #1 was at the ED. The facility was unaware that Resident #1 was not present in the facility.

Record review of "Past Weather in Grenada" dated 2/23/2023 revealed that 9:00 PM to 9:53 PM the temperature was 68 degrees Fahrenheit (F) with no precipitation.

Record review of "Google Maps" revealed that the address where Resident #1 was located was 236.22 feet from the window in Resident #1's room.

Record review of the Admission Record for Resident #1 revealed that the resident was admitted on 1/6/2023. Admitting diagnosis included Malignant Neoplasm of Nasopharynx, Unspecified, Secondary Malignant Neoplasm of Brain, Unspecified Psychosis not due to substance or known physiological condition, Major Depressive Disorder, Recurrent, Unspecified, Unspecified Mood (Affective) Disorder, and Unspecified Glaucoma.

A record review of "NEX-Wander Data Collection -V1" , with an effective date of 1/21/2023 revealed Resident #1 as High Risk for Wandering with a score of 28, and indicated that Resident #1 was cognitively impaired with poor decision making skills, has wandered, ...wandering places the resident at significant risk of getting to a potentially dangerous place (stairs, outside the

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facility), ...resident has visual, auditory or communication deficits, ...ambulate/perform locomotion independently ...,verbally expresses desire to go home ...,receives medications that may increase restlessness or agitation, ...new behavior, or change in functional status/routine .... Signed date 2/6/2023.

A record review of "NEX-Wander Data Collection -V1" , with an effective date of 2/6/2023 revealed Resident #1 as High Risk for Wandering with a score of 28, and indicated that Resident #1 was cognitively impaired with poor decision making skills, has wandered, ...wandering places the resident at significant risk of getting to a potentially dangerous place (stairs, outside the facility), ...ambulate/perform locomotion independently ...,verbally expresses desire to go home , ...new behavior, or change in functional status/routine .... Signed date 2/6/2023.

Record review of the Physician Orders for Resident #1 revealed that an order for "Wandergaurd-check for functioning Daily every shift" was started on 02/06/2023.

Record review of a Physician Order for Resident #1 dated 2/27/23 revealed the wander guard bracelet was placed on Resident #1 for wandering/exit seeking behaviors secondary to diagnosis of Malignant neoplasm of the brain.

Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date of 1/16/2023,Section C, revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #1 was cognitively intact.
Removal Plan

The facility failed to develop/implement a

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wandering/elopement risk care plan for Resident #1. The facility failed to provide supervision to prevent the elopement of Resident #1, who had exhibited exit seeking behavior. This failure allowed Resident #1 to be away from the facility unnoticed and unsupervised on 2-23-2023 until a nearby hospital alerted the facility at 9:53 PM that the resident was at the hospital. This was approximately 53 minutes after Resident #1 was last observed in the facility. On 3-2-2023 at 10:15 AM an immediate jeopardy (IJ) template was provided to the Nursing Home Administrator (NHA) by the State Agency (SA).

Immediate Action started on 2-23-2023 at approximately 9:50 PM

1. On 2-23-2023 at approximately 9:53 PM, Local Hospital Emergency Room (ER) called charge nurse phone to inform facility that Resident #1 was in the ER and looked "beat up" with lacerations and bruising. Local Hospital Emergency nurse said he still has his wander guard bracelet on. The Certified Nursing Assistant (CNAs) and Assistant Director of Nursing (ADON) looked into Resident #1's room and noticed that his window was open, and the screen had been bent/broken out and up to allow him to get out of the facility.

2. On 2-23-2023 at approximately 9:58 PM, the Nursing Home Administrator (NHA) notified Mississippi Department of Health and Attorney General Office.

3. On 2-23-2023 at approximately 9:58 PM an investigation was initiated and concluded on 3-1-2023 in which employee witness statements were collected.

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	22CI	A. BUILDING: _____ B. WING _____	C 03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CEN	1966 HILL DRIVE GRENADA, MS 38901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 640	Continued From page 12 4. On 2-23-2023 at approximately 9:58 PM, Assistant Director of Nursing conducted 100% resident audit and ensured all residents were accounted for and ensured two (2) residents with wander guard bracelets were in place and functioning properly. 5. On 2-23-2023 at approximately 10:23 PM, Assistant Director of Nursing notified Resident #1's Physician and Responsible Party. 6. On 2-23-2023 at approximately 10:40 PM, ADON went to the ER to interview Resident #1 and to assess Resident #1. 7. On 2-23-2023 at approximately 11:50 PM, the ADON initiated all staff members in-services on Abuse/Neglect, Resident Rights, Vulnerable Adults and Elopement policy and procedures which included, but does not limit to: Identification & Prevention of elopement, interventions, and documentation, at risk for elopement; monitoring, interdisciplinary interventions, door alarm sounds, procedure for missing residents/elopement, what to do when resident is found, and actions post elopement. No employee will be allowed to return to work without the training. 8. On 2-24-2023 at approximately 1:45 AM, upon return from to the facility Resident #1 was assessed and immediately placed on 1 on 1 observation. He was placed in room with 1 on 1 observation until resident was asleep and then every (Q)15 minute checks were initiated. 9. On 2-24-2023 at approximately 12:00 PM, Wander Guard System/Door were checked by Maintenance Department with no areas of concern nor malfunctions noted and, window alarm devices were added to Resident #1's new	M 640		

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M 640	Continued From page 13 courtyard room. 10. On 2-24-2023 between 8:00 AM and 4:30 PM, the Director of Nursing (DON) conducted a 100% audit for the risk of wandering for all 88 residents to include three residents already at risk for wandering. 11. On 2-24-2023 between 8:00 AM and 4:30 PM, the DON conducted a 100% audit of all wandering/elopement resident care plans. 12. On 2-24-2023 between 8:00 AM and 4:30 PM, the DON reviewed the wandering/elopement binders at each nurse's station and no updates were necessary. 13. On 3-2-2023 between 1:00 PM and 3:30 PM, the Regional Director of Clinical Services (RDCS) completed a 100% audit for all high risk wandering/elopement Residents Care Plans to ensure wandering/elopement care plans include appropriate interventions; Resident #1's and Resident # 3's care plans were updated. 14. On 3-2-2023 between 10:00 AM and 4:00 PM, the Staff Development Nurse (SDC) conducted and completed a 100% all Nursing staff in-service on developing Comprehensive Person Centered Care Plans to include interventions that address wandering and or high risk elopement residents. No employee will be allowed to return to work without the training. 15. On 3-2-2023 at approximately 4:45 PM, the Regional Director of Clinical Services (RDCS) in-serviced the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on identifying residents at risk for wandering/elopement and that they have the	M 640		

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M 640	Continued From page 14	M 640		

appropriate interventions in place. No employee will be allowed to return to work without the training.

16. On 3-2-2023 at approximately 6:30 PM, the Maintenance Department conducted an elopement drill and in-serviced staff members on the policy and procedures of elopement which included but does not limit to: Identification & Prevention of elopement, interventions, and documentation, at risk for elopement; monitoring, interdisciplinary interventions, door alarm sounds, procedure for missing residents/elopement, what to do when resident is found, and actions post elopement.

17. On 3-2-23-2023 at 2:00 PM the Ad-Hoc Emergency Quality Assurance Performance Improvement (QAPI) Committee met to review the immediate jeopardy related to F 689 Free of Accident/Hazards/Supervision/Devices and F 656 Develop/Implement Comprehensive Care Plan and conduct a Root Cause Analysis (RCA) and review policy and procedures for changes. Attendees were the Nursing Home Administrator (NHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Preventionist Nurse (IPN) and Regional Director of Clinical Services (RDCS). The Medical Director (MD) attended via phone. No Policy and Procedures changes were made at this time.

Facility alleges Immediate Jeopardy was removed as of 3-2-2023.

State Agency (SA) Validation on 3-3-2023

1. The State Agency (SA) validated through record review and interview with the Assistant Director of Nursing (ADON) that on 2-23-2023 at

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M 640	Continued From page 15 9:53 PM, after they were notified by the local hospital Resident #1 was at the hospital, the ADON and Certified Nursing Assistant (CNA) assessed Resident #1 ' s room and found the window was open and the screen was bent and broken. 2. The SA validated through record review and interview with the Nursing Home Administrator (NHA) and the SA complaint department, the elopement of a resident was reported to the State Department of Health on 2-23-2023 at 9:58 PM by the NHA. 3. The SA validated through record review and interview with the ADON that she initiated the investigation on 2-23-2023 at 9:58 PM and was concluded on 3-1-2023 by obtaining interviews, witness statements and observations. 4. The SA validated through record review and an interview with the ADON, a 100% audit of the residents, was performed on 2-23-2023 and begun at 9:58 PM to ensure they were accounted for and the two (2) residents with wander guard bracelets were in place and functioning properly. 5. The SA validated through record review and an interview with the ADON that on 2-23-2023 at 10:23 PM Resident #1 ' s Physician and Responsible Party were notified. 6. The SA validated through record review and an interview with the ADON on 2-23-2023 at 10:40 PM a visual assessment of Resident #1 was conducted at the local Hospital Emergency Room (ER) by the ADON. 7. The SA validated through record review and interviews with the ADON and eight (8) staff	M 640		

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M 640	Continued From page 16 members on 2-23-2023 from 11:50 AM to 1:00 PM, an in service was initiated and attended on Abuse/Neglect, Resident Rights, Vulnerable Adults and Elopement policy and procedures which included but is not limited to: Identification and Prevention of Elopement: interventions and documentation, At Risk For Elopement:, monitoring, interdisciplinary interventions, door alarm sounds, procedure for missing residents/elopement, what to do when resident is found, and actions post elopement. No employee will be allowed to work without the training. 8. The SA validated through record review and interview with the Director of Nursing, nurses and staff assigned to observations that on 2-24-2023 at approximately 1:45 AM, upon Resident #1 ' s return to the facility, he was assessed, placed on one (1) on 1 observation while awake and every 15-minute checks while asleep. 9. The SA validated through record review and interview with the Maintenance Department Director that on 2-24-2023 at 12:00 PM the Maintenance Director checked all Wander Guard System door alarms with no areas of concern nor malfunctions noted and, the window alarm was added to Resident #1 ' s room. 10. The SA validated through record review, and an interview with the DON that on 2-24-2023 between 8:00 AM and 4:30 PM she initiated a 100 % resident audit, for wandering, to include three (3) at high risk wandering residents. 11. The SA validated through record review and an interview with the DON that on 2-24-2023 at 8:00 AM and 4:30 PM she initiated an audit on all wandering/elopement resident care plans for appropriate interventions.	M 640		

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M 640	Continued From page 17 12. The SA validated through record review and interview with the DON the wander/elopement binders at the nurse 's stations were reviewed on 2-24-2023 at 8:00 AM and 4:30 PM for any needed updating. No issues were identified. 13. The SA validated through record review and an interview with the Regional Director of Clinical Services (RDCS) on 3/2/2023 between 1:00 PM and 3:30 PM she conducted an audit for all high risk wandering/elopement Residents Care Plans to ensure wandering/elopement care plans include appropriate interventions. Resident #1 and Resident #3 care plans were updated. 14. The SA validated through record review and interviews with facility staff that the Staff Development Nurse (SDC) conducted and completed an in service on 3/2/2023 at 10:00 AM and 4:00 PM with all nursing staff on developing Comprehensive Person Centered Care Plans to include interventions that address wandering and or high risk elopement resident. 15. The SA validated through record review and an interview with the RDCS that on 3-2-2023 at 4:45 PM she in serviced the NHA and the DON on identifying residents at risk for wandering/elopement and that they have the appropriate interventions in place. 16. The SA validated through record review and an interviews with staff that the Maintenance Department on 3-2-2023 at 6:30 PM conducted a facility wide elopement drill and in service to the staff on the policy and procedures of elopement which included but does not limit to: Identification and Prevention of elopement interventions, door alarm sounds, procedure for a missing resident,	M 640		

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M 640	Continued From page 18 what to do when a resident is found and actions post elopement. 17. The SA validated through record review and an interview with the Administrator on 3-2-2023 at 6:30 PM the Quality Assurance Performance Improvement (QAPI) committee met to review the immediate jeopardy related to elopement, elopement interventions and care plans related to elopement. The meeting was attended by the Nursing Home Administrator (NHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Control Preventionist Nurse (IPN), and the Regional Director of Clinical Services (RDCS). The Medical Director attended by phone. No policies were changed. The SA validated that all corrective actions to remove the IJ had been completed as of 3/2/2023, and the IJ was removed on 3/3/23, prior to exit.	M 640		